

1998

Development of rapid assessment protocols for evaluating the mental health status of incoming Bosnian refugees in Waterloo, Iowa

Susan Renee Dobie
University of Northern Iowa

Let us know how access to this document benefits you

Copyright ©1998 Susan Renee Dobie

Follow this and additional works at: <https://scholarworks.uni.edu/etd>



Part of the [Other Mental and Social Health Commons](#), and the [Social Work Commons](#)

Recommended Citation

Dobie, Susan Renee, "Development of rapid assessment protocols for evaluating the mental health status of incoming Bosnian refugees in Waterloo, Iowa" (1998). *Dissertations and Theses @ UNI*. 354.
<https://scholarworks.uni.edu/etd/354>

This Open Access Thesis is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Dissertations and Theses @ UNI by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Copyright by
SUSAN RENEE DOBIE
1998
All Rights Reserved

DEVELOPMENT OF RAPID ASSESSMENT PROTOCOLS
FOR EVALUATING THE MENTAL HEALTH STATUS
OF INCOMING BOSNIAN REFUGEES
IN WATERLOO, IOWA

An Abstract of a Thesis
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Susan Renee Dobie
University of Northern Iowa
July 1998

ABSTRACT

The purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in the adult Bosnian refugee population in Waterloo, Iowa.

An extensive literature review was conducted to research (a) refugeeism around the world, (b) causes of refugeeism, (c) the refugee experience, (d) refugee health challenges, (e) post-traumatic stress disorder in refugees, (f) depression in refugees, (g) acculturation stress in refugees, (h) rapid assessment procedures in public health, (i) rapid mental health assessments, (j) the case of refugeeism in the former Yugoslavia, (k) the history of refugeeism in the United States, (l) refugee resettlement in Iowa, (m) Bosnian refugees in Waterloo, Iowa, and (n) the need for rapid mental health assessment with Bosnians in Waterloo, Iowa.

The result was a 34-item questionnaire and protocols for its administration. Rapid assessment procedures for evaluating mental health for the adult Bosnian refugee population in Waterloo, Iowa, will be beneficial in a variety of ways. First, the Black Hawk-Grundy Mental Health Center, Inc. which is responsible for mental health care for this population needs to have prevalence data in order to better serve the population. Based on this information, the Center could add staff, facilities, or resources to accommodate needs. Also, baseline information is important to document needs in order to secure outside funding.

Secondly, the rapid assessment of mental health problems is beneficial to the Bosnian population. Those who are suffering from mental illness and at this time are

untreated or undiagnosed will not adapt to their new community as quickly or successfully as they could. The family of an afflicted person is also under added stress.

Third, this is an opportunity for the Black Hawk County Health Department to lead the way among small communities with large Bosnian refugee influxes. Currently, there is a lack of information available in the English language on the topic of rapid mental health assessment. This allows the Black Hawk County Health Department to serve as a model to the state, nation, and possibly the world as a testing ground for rapid mental health assessments. This quick and program-based information will allow for planning and growth opportunities for the future of the Black Hawk County refugee program.

DEVELOPMENT OF RAPID ASSESSMENT PROTOCOLS
FOR EVALUATING THE MENTAL HEALTH STATUS
OF INCOMING BOSNIAN REFUGEES
IN WATERLOO, IOWA

A Thesis
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Susan Renee Dobie
University of Northern Iowa
July 1998

This Study by: Susan Renee Dobie

Entitled: DEVELOPMENT OF RAPID ASSESSMENT PROTOCOLS FOR
EVALUATING THE MENTAL HEALTH STATUS OF INCOMING
BOSNIAN REFUGEES TO WATERLOO, IOWA

has been approved as meeting the thesis requirement for the
Degree of Master of Arts.

7-13-98

Date

Dr. Michele Yehieli, Chair, Thesis Committee

7/13/98

Date

Dr. Dennis Cryer, Thesis Committee Member

7-13-98

Date

Dr. Susan Koch, Thesis Committee Member

8/13/98

Date

Dr. John W. Somervill, Dean, Graduate College

ACKNOWLEDGMENTS

I would like to thank Drs. Michele Yehieli, Dennis Cryer, and Susan Koch whose insight and support allowed me to complete this project. I would also like to thank Tom O'Rourke, Public Health Director for Black Hawk County, for his support for this project. Thank you to my parents, Willis and Jean Roberts, for their encouragement and for teaching me the value of education. Finally, I would like to express my extreme gratitude to my husband and best friend, Mark, who is a constant reminder of what is important in life.

TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION.....	1
Significance of the Study.....	5
Assumptions.....	6
Delimitations.....	6
Limitations.....	6
Definition of Terms.....	7
II. REVIEW OF RELATED LITERATURE.....	10
Refugeeism Around the World.....	10
Causes of Refugeeism.....	12
The Refugee Experience.....	13
Refugee Health Challenges.....	16
Post-Traumatic Stress Disorder in Refugees.....	18
Depression in Refugees.....	21
Acculturation Stress in Refugees.....	23
Rapid Assessment Procedures in Public Health.....	27
Rapid Mental Health Assessments.....	29
The Case of Refugeeism in the Former Yugoslavia.....	30
The History of Refugeeism in the United States.....	37
Refugee Resettlement in Iowa.....	42
Bosnian Refugees in Waterloo, Iowa.....	43

CHAPTER	PAGE
The Need for Rapid Mental Health Assessments for Bosnian Refugees in Waterloo, Iowa.....	46
III. METHODS.....	48
Method of Questionnaire Development.....	48
Description of Individual Questions.....	50
IV. RESULTS.....	52
V. SUMMARY, DISCUSSION, AND RECOMMENDATIONS.....	56
Summary.....	56
Discussion.....	57
Recommendations.....	59
REFERENCES.....	61
APPENDICES.....	66
A. Symptom List from Dr. Mary Fabri.....	66
B. Questionnaire.....	72

CHAPTER 1

INTRODUCTION

April 4, 1992, Saturday. On this sunny early spring morning automatic weapon fire breaks out bringing with it two short but fateful words: CIVIL WAR. The war began unexpectedly and rapidly. So rapidly that we did not observe when it came through the door that was left ajar. It was the door of our previously peaceful and happy lives. The war came as an unknown stranger whom no one invited or loved. With him he brought his inseparable friends: DEATH, HUNGER, DISEASE, MISERY, and MISFORTUNE. (as cited in Mojzes, 1994, p. 13)

The preceding diary entry written by two unnamed Bosnian Muslim sisters describes their feelings the day they fled Bosnia, leaving their parents behind. As their words predicted, the war in the former Yugoslavia brought death to thousands of citizens who previously lived together in relative harmony. It brought hunger, disease, misery, and misfortune to many of those who survived. One group of people particularly affected by these factors are the refugees. In Bosnia, half of the country's four million citizens have been uprooted (U.S. Committee for Refugees, 1996).

The war in the former Yugoslavia has been very violent. The war was based on ethnic pride and desire for land, which led to savage attacks on lifelong friends and neighbors. Due to the war in the former Yugoslavia, thousands of people continue to leave their homeland. As refugees, they enter other areas of the former Yugoslavia, many European countries, the United States, and other countries. As of July 1998, about

2,300 Yugoslavian refugees have arrived in Waterloo, Iowa. At least 2,000 more are expected by the year 2000 (P. Woodsen, personal communication, July 2, 1998).

As Albert Einstein said, "A bundle of belongings isn't the only thing a refugee brings to his new country" (Loescher & Loescher, 1994, p. 45). Along with their few belongings, they bring the same talents, loves, and memories they possessed as citizens of a pre-war Yugoslavia. Now, though, they may also have memories of the ravages of war. Many of these refugees endured rape, torture, imprisonment, the death of family members, and the looting of their belongings. A citizen of this mostly cultured, relatively well-to-do, well-educated European country may now have psychological scars unthinkable to those who have never experienced war and betrayal firsthand.

Refugeeism is a common presentday worldwide phenomenon, occurring for a variety of reasons including war, famine, and politics. In fact,

a real picture of the world today would show millions of homeless men, women, and children, being forced north, south, east, and west--away from their homes, often away from their relatives--marching, stopping, marching; sailing, landing, sailing; shuffling, pausing, shuffling--often with no clear destination in sight, with little hope of return. (Kismaric, 1989, p. 30)

This shuffling of refugees, around a country or around the world, is often done in the mere hope of keeping the refugee alive long enough to return to their home when safety has been restored. Most refugees will return home eventually, if they are kept alive for a second chance (U.S. Committee for Refugees, 1996).

Surviving a war is a traumatic experience, and arriving in the United States does not automatically eliminate the trauma. While trying to assimilate to the new country the refugee faces other crises. Physically, refugees may be separated from the situation in

their homeland, but emotionally they are still bound by concern for the friends and family that remain there. The news they hear from or about their homeland may also bring to mind past traumatic experiences. Other sources of stress for the refugee are cultural differences. Embarrassment can easily follow a misunderstood custom. The language barrier also poses an obstacle to the ease of assimilation of the refugee. The typical stereotypes of refugees by members of the host country may also cause many unpleasant experiences (van der Veer, 1992).

Refugees may suffer from clinical depression or post-traumatic stress disorder. Clinical depression is expected due to the fact that it is associated with negative life events, such as the loss of a loved one, a divorce, a move, a major financial upheaval, or other loss (U.S. Department of Health and Human Services, 1991). Virtually all refugees will have recently experienced all of these events, with the possible exception of divorce. This puts them at risk for clinical depression. A diagnosis of post-traumatic stress disorder (PTSD) necessitates a person having experienced an event which is outside the range of human experience that would be markedly distressing to almost anyone (van der Veer, 1992). There is no question that war, the loss of family, and the loss of homeland would be markedly distressing to most people.

The newest refugees entering Waterloo, Iowa are from Bosnia, a republic of the former Yugoslavia. Due to its location within the country and its mixed ethnic heritage, much of the fighting in the former Yugoslavia took place in Bosnia. Many towns were destroyed, and many Bosnians had to evacuate to save their lives. In fact, more than

one-half of Bosnia's population remained uprooted in 1995 (U.S. Committee for Refugees, 1996).

The combination of witnessing and enduring traumatic events and the stress of cultural assimilation makes Bosnian refugees prime candidates for both depression and post-traumatic stress disorder. In order to determine the potential need for services in these areas, a tool is needed to screen for symptoms of these illnesses. Both post-traumatic stress disorder and depression require a clinician's diagnosis. The symptoms though, can be self-reported.

Rapid Assessment Procedures (RAP) are formative research tools frequently used in the fields of epidemiology and anthropology. According to the United Nations Development Programme (UNDP; 1998), the goal of RAP is to generate programmatically useful information. RAP allow for a nearly immediate summary of a situation, as they only take 6 to 12 weeks to process. There are a variety of methods and techniques to do this, one of which is the questionnaire. The basic features of RAP are their rapidity, simplicity, cost-effectiveness, and immediate feedback (UNDP, 1998). The availability of this information is necessary to plan a rapid response and detect early warning signs of problems (Guha-Sapir, 1991).

A rapid assessment tool focusing on symptoms of post-traumatic stress disorder and depression will not have the accuracy of a clinician's diagnosis. In other rapid assessment situations, this limitation is overlooked in favor of gathering statistical estimates to formulate rapid responses to crisis situations (Guha-Sapir, 1991). This compromise between time, quality, and cost of the research justifies rapid assessment

procedures when “it is better to get some information quickly, than none at all” (UNDP, 1998, p. 5). The amount of time and costs required for a clinician to assess individuals prohibits the use of lengthy diagnostic tools and individual evaluations of every refugee.

A short, anonymous questionnaire asking yes and no questions about common symptoms of PTSD and clinical depression collected from each adult Bosnian refugee arriving in Waterloo, Iowa, would allow assessment of the prevalence of the symptoms of these disorders. This is needed to determine the extent to which the Black Hawk County Health Department should provide mental health services to this population. Therefore, the purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in the adult Bosnian refugee population in Waterloo, Iowa. These RAP could also be used by other local health departments in the state of Iowa challenged with an influx of Bosnian refugees.

Significance of the Study

With the current number of Bosnian refugees in Waterloo around 2,300 and an expected 100 more refugees per month over the next two years, it is important to estimate the potential need for psychological counseling for this population. The development of this questionnaire provides a tool for the Black Hawk County Health Department and the Black Hawk-Grundy Mental Health Center, Inc. to determine if additional staff, facilities, or supplies are needed to serve this population. Until this point, there has been no systematic study of the mental health needs of the Bosnian refugees in the Waterloo area.

Assumptions

These protocols were developed under the following assumptions:

1. The respondents have been exposed to circumstances because of their situation that may predispose them to mental trauma.
2. A portion of the respondents are suffering from post-traumatic stress disorder and/or depression.
3. The respondents will be able to read and comprehend the written questions in order to respond to them accurately.
4. The respondents will underreport symptoms.

Delimitations of the Study

These protocols were delimited to:

1. Adult (over age 18) refugees from Bosnia-Herzegovina.
2. Refugees entering Black Hawk County, a small county (population 125,000) in the Midwest.

Limitations of the Study

These protocols were limited by:

1. Respondents who are illiterate will not respond accurately to the questions or will be unable to participate.
2. Rapid assessment procedures are not as accurate as a clinician's diagnosis of either post-traumatic stress disorder or depression.
3. The researcher was unable to utilize foreign language documents to research this topic.

Definition of Terms

1. Refugee: According to the United Nations (1996), a refugee is:

any person who, owing to well-founded fear of being persecuted for reason of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, unwilling to return to it. (p. 8)

2. Depression: According to the U.S. Department of Health and Human Services (1991), depression is a combination of the intensity and duration of emotion and symptoms that indicate depression has ceased to be a temporary mood and become a clinical state. Symptoms of depression include any or several of the following: persistent sad, empty, or anxious mood; loss of interest or pleasure in ordinary activities, including sex; decreased energy, fatigue; sleep disturbances (insomnia, early-morning waking, or oversleeping); eating disturbances (loss of appetite and weight, or weight gain); difficulty concentrating, remembering, or making decisions; feelings of hopelessness or pessimism; thoughts of death or suicide; suicide attempts; irritability; excessive crying; and chronic aches and pains that do not respond to treatment. When four or more of these symptoms persist for more than two weeks or are causing impairment in ordinary functioning, professional treatment, including medical evaluation, should be sought.

3. Post-traumatic stress disorder: According to the American Psychiatric Association (APA), the diagnostic criteria for post-traumatic stress disorder is:

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by a disorganized or agitated behavior.

- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
 - (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have love feelings)
 - (7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (APA, 1994, pp. 427-429)

4. Ethnic Cleansing: According to the Geneva Convention, ethnic cleansing is “violence committed with specific intent to destroy, in whole or in part, a national, ethnic, or religious group” (Stephens, 1993, p. 13).

CHAPTER 2

REVIEW OF RELATED LITERATURE

The purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in the adult Bosnian refugee population in Waterloo, Iowa. This chapter presents a review of related literature in the following subject areas: (a) Refugeeism around the world, (b) Causes of refugeeism, (c) The refugee experience, (d) Refugee health challenges, (e) Post-traumatic stress disorder in refugees, (f) Depression in refugees, (g) Acculturation stress in refugees, (h) Rapid assessment procedures in public health, (i) Rapid mental health assessment, (j) The case of refugeeism in the former Yugoslavia, (k) History of refugeeism in the United States, (l) Refugee resettlement in Iowa, (m) Bosnian refugees in Waterloo, Iowa, and (n) The need for rapid mental health assessment with Bosnian refugees in Waterloo, Iowa.

Refugeeism Around the World

Refugees, by simple definition, are ordinary people who have left their countries to escape war, persecution, and/or human rights abuse (United Nations High Commissioner for Refugees [UNHCR]; 1996). The formal definition, according to the United Nations, is

any person who, owing to well-founded fear of being persecuted for reason of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, unwilling to return to it. (United Nations, 1996, p. 8)

Internally displaced persons are people who left their homes for the same reasons as refugees, but have not yet crossed an international border (U.S. Committee for Refugees, 1996).

In 1951, the United Nations High Commissioner for Refugees was created to help the existing post-World War II refugees integrate into the societies in which they had found refuge. The Commission's projected life span was three years. After that, it was to be disbanded. The need for this organization though, never diminished (UNHCR, 1993).

It is difficult to accurately count refugees. What one country calls a refugee, another may call an illegal alien. A person who is internally displaced today may be a refugee tomorrow. According to the UNHCR, there were 49 million refugees worldwide in early 1995. This includes 23 million people who had fled across international borders and 26 million people who were displaced in their own country (as cited in Holman, 1996). One in every 255 people on this planet is a refugee (UNHCR, 1996).

The origins of the major refugee populations and persons in refugee-like situations show just how worldwide this problem is. Currently, the Afghans represent the world's largest refugee population, with 2.6 million Afghans living in Iran, Pakistan, and India. The Afghans are seeking refuge from the fighting between old and new factions in the Afghan government. These factions are a complicated mix of ethnic, regional, political, and religious entities. Afghans are also leaving due to control by the Taliban. This group is closing all the schools for girls, requiring women to be covered from head to toe, and no longer allow women to work outside the home, except in the health care field (U.S. Committee for Refugees, 1996).

Liberia is the second greatest source of the world's refugees. The civil war there has sent 778,000 Liberians to Ghana, Nigeria, or Guinea and internally displaced another one million persons. At one point nearly three-fourths of the population was uprooted from their homes. Bosnia and Herzegovina follows Liberia with nearly 1.2 million citizens either internally displaced or living as refugees (U.S. Committee for Refugees, 1996). The war that has caused this displacement will be discussed in detail later in this research.

Causes of Refugeeism

The reasons for a refugee's flight are rarely simple. Causes may be interwoven and could include political, economic, or environmental reasons, and/or ethnic tensions. Persecution is one root cause of refugeeism. This may be based on race, nationality, membership in a particular social group, or this could be based on beliefs such as religion or politics. History reports many examples of refugees created from political persecution including Pol Pot in Cambodia and the Kurds in Iraq under Saddam Hussein. The national government is not always behind these situations, as armed opposition groups also perform acts that create refugees. Examples include the Shining Path in Peru and the nationalist groups in Bosnia and Herzegovina. Most of today's refugees are not fleeing targeted acts of individual violence, but ethnic violence that threatens civilian life and disturbs everyday routine (UNHCR, 1993).

Economics also creates a large number of refugees. This may include financial deprivation, but also conflicts from the efforts to preserve or advance one group's standing at the expense of another group. The distribution of resources during economic

decline may also spur a deluge of refugees. However, poor economic conditions can contribute to refugeeism by exacerbating ethnic and community tensions (UNHCR, 1993).

The environment also contributes to refugee flow. When a natural disaster strikes, land may become uninhabitable, forcing people to leave. In recent years, Mount Pinatubo, in the Philippines, the Chernobyl disaster in the Soviet Union, and the gradual disappearance of rain forests in Brazil have created environmental refugees. Additionally, countries may have inadequate food surplus, infrastructure, or emergency systems to withstand natural disasters. These situations not only create refugees, but also fuel other problems such as demographic pressure or chronic poverty (UNHCR, 1993).

Today's nations are rarely ethnically homogeneous. In the approximately 190 countries that exist today, about 5,000 ethnic groups reside. This makes the idea of a pure ethnic state nearly impossible without a high human cost. From these tensions, ethnic cleansing may flow, or populations may be forcibly segregated. Palestine and the Punjab in 1948, and Bosnia and Herzegovina today, offer dramatic examples of this situation (UNHCR, 1993).

The Refugee Experience

Not every refugee's experience is exactly alike, and each one's experience does not take place within a set period of time. On the whole though, experiences that relate to psychological acculturation and eventual adaptation can be classified according to the time (or phase) at which they take place. These phases can be labeled: Pre-Departure, Flight, First Asylum, Claimant Period, Settlement Period, and Adaptation (Berry, 1991).

Each phase includes experiences that are unique from and common to the other phases. According to Berry's (1991) description, these phases allow for an understanding of the implications of the flight of the refugee.

During the Pre-Departure phase, the refugee faces the most traumatic events that will later put him/her at risk for mental health and social problems (Berry, 1991). Events prior to departure may include civil wars, revolutions, floods, violence, and ethnic or religious conflict, among others. Whatever the conditions, they are perceived as unbearable (Ben-Porath, 1991). Tyhurst (1982) has suggested that pathological symptoms such as paranoid behavior, somatization, anxiety, depression, and sleep disturbances which have been observed in a variety of groups of refugees, are to a great degree, manifestations of the effects of premigratory stress (as cited in Ben-Porath, 1991). During this period, stress builds and accumulates into Pre-Departure trauma (Berry, 1991).

The stress during flight may include fear of starving or being captured, injury, torture, or death. Refugees may also be worried about leaving behind belongings and family. Flight is often chosen rapidly and even if it is not dangerous, social and financial loss, and separation from homeland are almost always necessary.

The history of groups' flights to the United States vary considerably. Soviet Jews had to first apply to immigrate to Israel. Upon reaching Vienna, they could change their destination to the United States, which first sent them to Rome to be processed. This could be a lengthy process. Indochinese refugees had a much different experience. Many stayed in camps in Thailand, which had little security and few supplies. Others

trying to escape Vietnam fled in boats. Some died when the boats sank. Others experienced theft, beatings, rapes, and murder by pirates (Haines, 1996).

Upon arrival at the site of first asylum, refugees are often happy and relieved. The initial elation may be followed by fear and anxiety. There may still be fear for personal safety and uncertainty about the future. At this point, refugees can still be deported to their country of origin, or to another asylum camp. The refugee may now realize that immigration is a long, involved process (Berry, 1991). Refugees may also lose some sense of individuality as they become a number in the “gray, anonymous mass of refugees” (Ben-Porath, 1991, p. 7).

With certain stipulations and limitations, refugees are entitled to asylum by countries that have signed the UN Convention (claimant phase). However, many are still turned away. This can cause great emotional distress. If asylum is denied, the refugee may become depressed. If asylum is granted, elation and relief may continue, but resentment over past treatment may begin. After being granted asylum, the refugee may have conflicts with citizens or officials within the host country. The refugee may be faced with problems accessing health care, social services, employment, or education. This may cause the refugee to feel marginalized within his/her new community (Berry, 1991).

During the settlement phase, the host country officially accepts the refugee as a potential citizen, along with all the rights and freedoms of native citizens. Barring any destructive settlement policies, such as scattering refugees or sponsors looking for cheap labor, refugees usually settle without serious difficulty. The acceptance by the host

country may be gradual (Berry, 1991). Just as refugee situations vary by time and location, their reception into the community may vary, too. Early Cuban refugees came as exiles to the U.S. from a communist nation at odds with the U.S. Government. They enjoyed strong political support due to public opinion of Fidel Castro in the United States. Many of the Southeast Asian refugees were also from communist countries. However, since they were reminders to the public of an unpopular war, they received less initial support from communities in the United States (Haines, 1996).

The final phase is adaptation. During this phase, most, but not all refugees, make satisfactory long-term adaptation to the new society. Those who do not will need continued services from the host country. This phase may take months or years, and may not occur at all in some cases (Berry, 1991).

Refugee Health Challenges

The major causes of morbidity and mortality in refugee camps are diarrheal and infectious diseases, malnutrition, pneumonia, upper respiratory tract infections, and skin diseases. Due to these specific health concerns, the provision of food, water, and shelter is initially more important than medical care (Sandler & Jones, 1987).

A clean and adequate supply of water is essential. If the source of the contaminated water is left uncorrected, diarrheal and parasitic diseases will continue. Food is also very important in the refugee camp situation. Initially vitamins, powdered milk, and high protein foods will relieve hunger. They are not a permanent solution though. Continuing proper nourishment needs to agree with the local customs and tastes (Sandler & Jones, 1987).

Once these needs are fulfilled, health care workers can deliver their services.

Although the specific diseases will vary by country of origin, nearly all refugees will have a higher incidence of tuberculosis, chronic infection with hepatitis B, intestinal parasites, nutritional deficiencies, and depression compared to the host population (Ackerman, 1997).

Upon arrival in developed asylum countries, like the United States, many refugees suffer from major medical problems. Early on, anemia and skin, respiratory, and gastrointestinal problems are common, along with more serious conditions, such as malaria, hepatitis, and tuberculosis. Concerns about Southeast Asian refugees, for example, led to improved medical screening overseas before entry into the United States (Haines, 1996). All refugees must receive an overseas medical exam within one year prior to entering the United States. According to the Centers for Disease Control and Prevention (CDC), this excludes those who have communicable diseases of public health significance, current or past mental disorders that are or have been associated with harmful behavior, or drug abuse or addiction (as cited in Ackerman, 1997). Upon entry into the United States, all refugees must pass through the U.S. Public Health Service Quarantine Station at their port of entry. Refugees that appear ill can be detained there (Ackerman, 1997).

Other diseases may appear upon resettlement. Rasbridge (1994) notes the prevalence of hypertension, alcohol-related problems, and gastritis in various refugee groups (as cited in Haines, 1996). Mental health concerns may also surface during the resettlement phase (Berry, 1991). Phan (1994) notes that other health-related issues may

not be linked to relocation at all, such as the high rates of smoking among certain ethnic groups (as cited in Haines, 1996).

Post-Traumatic Stress Disorder in Refugees

One of the most important chronic conditions facing many refugees is post-traumatic stress disorder. PTSD is a

severe and often chronic biopsychosocial disorder over which patients have little control and which affects many areas of their lives. Patients are not free to choose their symptom(s), its development, nor the impairment that ensues. At the most clinically intense stages of PTSD, patients suffer severe anguish, often depression, and are afflicted by a multitude of intrusive symptomology that includes nightmares, reexperiencing, startle reactions, and hyperarousal states. (Kinzie & Boehnlein, 1993, p. 92)

In order for a patient to be diagnosed with PTSD, the American Psychiatric Association (1994) requires the following six criteria be met. The person must have been exposed to a traumatic event. The traumatic event is now reexperienced in one or more ways. The person persistently avoids stimuli associated with the trauma and experiences numbing of general responsiveness. The person has persistent symptoms of increased arousal. The duration of the disturbance has lasted more than one month. Finally, the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Multiple investigators have found that the diagnosis of PTSD is often applicable to refugees who present mental problems. According to Op den Velde (1989) symptoms of PTSD are usually manifested within three months of the traumatic experience. Symptoms may not appear until much later. The amount of time could vary from 5 years to 25 years after the experience (APA, 1994).

In 1989, Jensen, Schaumburg, Leroy, Larsen, and Thorup compared refugees and immigrants receiving care in three psychiatric units in Frederiksborg County, Denmark, over a five year period. The hypothesis was that the patient groups would be different because the immigrants chose to leave their countries versus the refugees who were pushed out of their countries. The study did find statistical differences between the groups. None of the immigrants fulfilled the diagnostic criteria for PTSD, while 69% of the refugees did. The same study found that nearly half of the refugees were in acute crisis, compared to only 2% of the immigrants.

Westmeyer (1995) reports especially high rates of PTSD in refugees compared to the indigenous United States population. According to Westmeyer (1995), the involuntary loss of country, occupation, and status that often accompanies a refugee's flight, along with the high incidence of torture, other violence, and terror in this group increases their risk for PTSD. Westmeyer (1995) also found that PTSD is precipitated and/or perpetuated by certain factors in certain groups, including refugees. These factors include unemployment, marital discord, geographic relocation with diminution of social network, theft/robbery/vandalism of one's property, and other stresses. Westmeyer (1995) cautions that if these factors are not effectively addressed, the national costs for disability and unemployment could escalate.

In work with survivors of torture and trauma at the Victorian Foundation for Survivors of Torture, in Victoria, Australia, McGorry (1995) found that the majority of refugees there had been significantly traumatized by their experience and had undergone multiple losses. Most survivors also reported the key symptoms of PTSD. Not all of

these people would meet the full criteria for PTSD. McGorry (1995) also reported significant levels of anxiety and/or depression among subjects.

Locke, Southwick, McCloskey, and Fernandez-Esquer (1996) investigated the psychological sequelae of exposure to war in Central America. They examined 22 immigrant women and their children. The children ranged in age from 5 to 13. Only 2 of the 22 children met all of the criteria for post-traumatic stress disorder. Sixteen of the children met the criteria for at least one of the three symptom groups of PTSD. The female caretakers had been exposed to more violence than the children. Four of the caretakers met all of the criteria for PTSD. All but one caretaker met the criteria for at least one of the symptom groups. All of the women had been exposed to at least three different types of traumatic events, although most had been exposed to more. Significant correlations were found between the more symptomatic caretaker's reports and their children's reports of total number of PTSD symptoms. The study showed no relationship between the length of time since the children left Central America and the number of symptoms they experienced. There was also no relationship between the level of violence the children were exposed to and the level of traumatization.

Symptoms of PTSD are often misdiagnosed in refugees as schizophrenia, according to Gong-Guy, Cravens, and Patterson (1991). These symptoms, flashbacks, hallucinations, and dissociative phenomena are typical of PTSD. Gong-Guy et al. (1991) found PTSD and symptoms of the disorder to be prevalent among refugees.

Weine et al. (1995) recorded psychiatric assessments and trauma testimonies of 20 Bosnian refugees who experienced ethnic cleansing. The refugees had resettled in

Connecticut a few months prior to the study. Nearly all the subjects had their homes destroyed, were forced to evacuate their towns, experienced serious shortages of food and water, had family members disappear without explanation, were exposed to acts of violence, experienced the death of at least one family member, were detained in a refugee camp, and experienced forced emigration. The authors noted that these experiences are not unusual among refugees from Bosnia. Of the 20 subjects, 65% met the full criteria for PTSD. The two most frequently occurring symptoms were intrusive memories and avoiding thoughts of the war.

Weine et al. (1995) found that older age (middle and late adulthood) was associated with a diagnosis of PTSD. They also found that the adolescents in the study did not have PTSD. This may be due to a guarding of the children by their parents, or a child's ability to use traumatic play and cognitive distortions to manifest emotional distress.

Depression in Refugees

Among refugees, the symptoms of major depression often accompany the symptoms of PTSD. The most important symptoms of this condition are a depressed mood and a loss of interest in most activities, almost all day, every day. When the criteria of PTSD and major depression are placed side by side, the similarities are apparent. In the case of refugees, the use of both diagnoses together is often appropriate (van der Veer, 1992).

Mollica and Lovelle (1988) report that for depression in particular, refugees present with somatic complaints. Refugees may acknowledge their psychological

symptoms, but only view their somatic complaints as needing medical attention (as cited in Gong-Guy et al., 1991). Physicians, then, according to Gong-Guy et al. (1991) should be alert to depression when refugees present somatic complaints because of the prolonged debilitating depressive disorders found in refugee populations.

Gonsalves (1990) interviewed 32 Chilean refugees who had been exiled to the United States. Gonsalves (1990) found the immediate affective outcome of the exile was depression. This response deepened in the weeks after their arrival. Two months later, job training classes began and some of the refugees reported more positive feelings. In 10% of the sample though, the depressed mood that afflicted them never left.

Tran (1993) suggests that the relationship between psychological traumas and depression can be explained by the learned-helplessness theory. This suggests “learning that outcomes are uncontrollable results in three deficits: motivational, cognitive, and emotional” (p. 185). This means that a sense of helplessness resulting from a traumatic event is destructive to a person’s self-worth. This psychological phenomenon is often associated with depression (Tran, 1993).

Sack, Clarke, and Seeley (1996) interviewed 106 adolescent Cambodian refugees who had been in Portland, Oregon, for one year. The prevalence rate for mild depressive disorder among the teens was 12.9%. This is nearly four times higher than the 2.6% prevalence rate in the control group of native Portland students.

In the same study mentioned earlier, Weine et al. (1995) also looked for symptoms of depression. Of the 20 Bosnians recently resettled in Connecticut, 35% met the criteria for a depressive disorder. The depressive disorders ranged from major

depression, to nonspecified depressive disorders. Symptoms included widespread grieving, demoralization, and humiliation.

Acculturation Stress in Refugees

Redfield, Linton, and Herskovits defined acculturation as “culture change that results from continuous, first hand contact between two distinct cultural groups” (as cited in Berry, 1991, p. 190). This process applies at the individual level as well as the group level. In a refugee situation, changes occur in both the dominant and non-dominant groups. For example, among individuals in the dominant group, values and attitudes could change leading to a more or less hospitable climate to newcomers. Most changes though, will occur in the non-dominant culture (Berry, 1991).

Berry (1991) defines stress as a

generalized physiological and psychological state of the organism, brought about by the experience of stressors in the environment, and which requires some reduction (for normal function to occur), through a process of coping until some satisfactory adaptation to a new situation is achieved. (p. 194)

Acculturation stress refers to one kind of stress with roots in the process of acculturation.

Lin (1986) noted that consistently over the last 40 years, research has shown that most refugee groups encounter similar kinds of adaptational difficulties and tend to develop similar problems (as cited in Ben-Porath, 1991). Thus, common problems and experiences usually transcend individual, national, and cultural bounds (Ben-Porath, 1991).

Berry (1991) suggests a variety of changes that can exist as stressors as a result of acculturation. First, physical changes occur in refugees' lives, such as a new place to

live, different population density, and more or less pollution. Not only are refugees relocating, they may have difficulty affording or finding available appropriately-sized housing. Large families looking for rental property may have extra difficulty. Housing the refugee can afford may not be ideal because of distance from employment and physical safety. A family may need to live in a high-crime area in order to find low-cost, multi-bedroom rental housing (Haines, 1996).

Second, biologic changes occur. This could include a different diet. Certain spices, vegetables, or other diet staples may not be readily available in the host country. Refugees may have to order these items or request that a local store begin to carry them. A new environment may also mean exposure to new diseases. In certain cases, these have been devastating in force (Berry, 1991).

Third, there are political changes (Berry, 1991). Refugees may come from Communist or Socialist backgrounds. The state may have restricted their freedoms, as was the case for the Jews in the Soviet Union. The state may have provided their basic needs such as food, shelter, and employment. This may make certain concepts such as entrepreneurialism or the concept of a self-initiated job search difficult to understand (Haines, 1996).

Next, economic changes occur (Berry, 1991). Refugees may move from their traditional employment to a different field and their standard of living may change. Although there are variations between individuals, generally, refugees entering the United States have advanced occupational skills and educational levels compared to their peers in their country of origin. Often these are also higher than the general U.S.

population. However, because of their lack of English skills or certification in the U.S., they may be unable to work to their full potential and may work menial jobs. This could provide great stress. A smooth job transition has been shown to ease the transition to a new life (Haines, 1996).

The ability to speak English is clearly linked to success in finding employment. A 1992 survey by the federal Office of Refugee Resettlement showed employment rates corresponded to high levels of English-language skills: 5% for those with no English, 26% for those with some English, and 44% for those who spoke English well (as cited in Haines, 1996).

In order to reach some economic self-sufficiency there usually needs to be more than one wage earner per family. Thus, if refugees arrive in the U.S. believing that women working outside the home is acceptable and important, the family is more flexible in achieving economic self-sufficiency (Haines, 1996).

For many refugees it is underemployment, not unemployment that is the greater plague. Many refugees come to the U.S. with strong educational and occupational backgrounds, yet are unable to find work commensurate with their education and experience. Major obstacles include non-recognition of degrees and skills, licensing restrictions by trades and professions, the retraining needed due to national differences, the need for language skills, and the non-transferability of certain skills. Thus, surveys indicate a more general shift from 'white collar' to 'blue collar' work (Haines, 1996).

Cultural changes also occur (Berry, 1991). These changes lie at the heart of acculturation. These may include a switch in language, religion, and education. Changes

may be made by necessity or by choice. Religion especially may be affected by the host culture. Lack of church services in a refugee's language, or practices that do not precisely fit with existing mainstream churches may cause difficulty in practicing a religion. Refugees who choose to convert to a mainstream religion may move away from traditional religious practices that are also closely related to ethnic identity (Haines, 1996).

Next, there is a shift in social relationships (Berry, 1991). Haines (1996) stresses the importance of family to adjustment in the new culture. Family often provides both emotional and financial support. Family may also create conflict. The new role of the woman working outside the home may strain domestic relations. Children also face specific concerns. They are caught between traditional culture and the culture of the host country. Successful assimilation to the new culture may mean discarding traditional cultural values and perspectives. The extent to which a refugee is concerned about reconstructing family ties with those still in their homeland also contributes to the stress a refugee experiences.

Finally, during acculturation there are numerous psychological changes that occur on the individual level (Berry, 1991). Personal identity and ethnic identity may change over time. There may also be changes in behavior, values, beliefs, and motives. Other attitudes, such as intergroup attitudes and lifestyle preferences, may develop throughout the acculturation process (Berry, 1991).

According to Haines (1996), a refugee's adjustment depends not only on cultural characteristics, but also on basic population demographics, such as age or sex. Elderly

refugees who are unfamiliar with the English language and American culture may find adaptation to the U.S. much more difficult than a child who adjusts quickly to new customs. This adjustment may come at the expense of departing from the first language and culture. Women may also have more difficulty adjusting to a new culture. Due to their roles as wives and mothers, they may spend more time in the home and may not be exposed to experiences that would help in the acculturation process (Haines, 1996).

Rapid Assessment Procedures in Public Health

Anthropologists traditionally spend many years learning a discipline and many more years learning about other cultures. Recently, anthropologists have brought these methods and perspectives to bear on the evaluation and improvement of primary health care services. The large amount of time in the field required to collect theoretical material by ethnography can be accomplished in less time by a simpler approach, rapid assessment procedures (RAP). RAP provide health care workers, researchers, and social scientists guidelines to conduct rapid assessments of health behaviors and other behaviors of interest (Scrimshaw & Hurtado, 1987).

The goal of RAP in public health is to generate programmatically useful information. This is done by rapidly compiling and analyzing relevant information for program purposes. From implementation to the availability of results, rapid assessment procedures usually take between 6 and 12 weeks. There are various approaches to rapid assessment including community diagnoses, situational analyses, rapid anthropological assessments, rapid epidemiological assessments, rapid nutritional assessments, and others (United Nations Development Programme [UNDP]; 1998).

Rapid assessments are generally used for program planning and policy making, not database building. In using RAP there is a trade off between time and quality of data. Thus, it is important to have clear goals when designing the assessment. RAP is limited by observer, participant, and recall bias. Also, the group assessed over a short period of time may not be representative of the whole. Thus, conclusions drawn should be action-oriented, as with applied-research, for specific goals (UNDP, 1998).

Rapid assessment procedures have been used with refugees in a variety of settings. In Tanzania, in 1994, an eight day rapid assessment procedure was used to measure sexually transmitted disease (STD) prevalence among Rwandan refugees. According to Mayaud et al. (1997) in refugee crises, epidemiological rapid assessments can be used to prioritize health responses quickly. The study found that the ability to quickly collect reliable STD information at a low cost ensured that STD control was given higher priority in the refugee camp.

In the camps for Kampuchean refugees in Sa Kaeo, Thailand, Glass et al. (1980) used rapid assessment procedures to assess health status and preventive medicine needs of the refugees. Through RAP, CDC epidemiologists identified the principle causes of death and severe illness in order to establish the need for public health interventions. The researchers found many people were dying outside the hospital. After a door-to-door check was initiated, the death rate dropped quickly. The findings influenced the health care of the refugee camp and delivery of medical services in subsequent camps. The use of rapid assessment procedures allowed the health programs to be based on facts which

led to more efficient and appropriate use of health resources. This use of surveillance allowed workers to reduce preventable causes of death and illness.

Rapid Mental Health Assessments

There is limited information on using rapid assessment procedures in mental health. The researcher was only able to locate two articles in English related to RAP and mental health.

Rapid assessment of mental illness is necessary for emergency psychiatric service in a walk-in clinic due to limited time with the client. Lazare (1976) suggests a technique to help the clinician make efficient use of his/her time by eliciting specific data. These data are used to confirm or refute a clinical hypothesis rather than gathering a complete history.

Lazare's (1976) approach proposes 16 hypotheses that provide the data necessary to make a clinical decision. Based on observations made early in the interview, a clinician would consider a limited number of diagnoses. The 16 hypotheses are then reviewed to ensure the clinician is not coming to premature closure. Lazare (1976) admits that this method relies on a psychiatrist's initial intuition. Yet, at times there is a limited amount of time to decide if a patient is suicidal or needs to be admitted to a hospital. It can be difficult to collect large amounts of data prior to making an emergency decision.

Hanks, Trueman, House, Evans, and Ancill (1985) experimented with patients attending a regional pain relief unit in Oxford, England. To rapidly assess depression and anxiety, computer administered rating scales were used. Monitoring mood changes over

time would take a psychiatrist or psychologist far more time than is available in a typical clinic setting. In this study, the computer scores and physician's assessment were frequently different, although in other studies, the microcomputer has shown to be accurate and practical in assessing patients. The differences between the clinician's and the computer's rating may signal a group of patients who are unrecognized and untreated.

The reason there may be little information on rapid mental health assessment is the lack of collaboration between the field of psychiatry and the field of public health. Historically, what may be known to the clinician is not being utilized by the public health practitioner.

The Case of Refugeeism in the Former Yugoslavia

The former Yugoslavia has never been considered a melting pot. The country, since its birth in 1929, has been home to many ethnic groups (i.e., Slovenians, Macedonians, Croatians, Montenegrins, Serbians, Albanians, Hungarians, Gypsies, and Bosnians). Each of these populations has distinct national and linguistic characteristics. Some of these groups are defined by the land they inhabit. Some are related and others are not. History does not reveal whether all of these groups began as one and evolved into many. The land originally was divided by religious affiliation or by feudal claims of powerful overlords. The nationalism that has splintered this country is a modern phenomenon with deep historical roots (Mojzes, 1994).

At the end of World War I, the Kingdom of Serbs, Croats, and Slovenes was created from the fallen Austro-Hungarian Empire. In 1929, this land became known as the Kingdom of Yugoslavia, meaning the land of the southern Slavs. This all inclusive

name was not an omen of unity. The country quickly became a mixture of contending ethnicities. It became impossible to accommodate the desires of each group. This directly encouraged the intercommunal slaughter of World War II (Manners, 1996). During this time, Yugoslavia was invaded by Hitler. The Serbs led a war of liberation against the Nazi occupation. This led to a reunification of a liberated Yugoslavia in 1945. Despite the great Serb effort during the war, the credit for the victory was given to the Communist Party. The multinational Communist Party described the revolution as a socialist revolution of all Yugoslavian people (Mojzes, 1994).

When World War II was over a Communist, Josip Broz Tito, came to power. He divided the country into six republics: Slovenia, Croatia, Serbia, Montenegro, Macedonia, and Bosnia and Herzegovina (which will be referred to as Bosnia).



Borders were imposed without any discussions or negotiations. Serbia was granted a smaller territory than it had hoped for. Serbia was also the only republic to contain autonomous regions. It contains Vojvodina and Kosovo. These events laid the groundwork for events in coming decades (Mojzes, 1994).

Tito ruled Yugoslavia for nearly 40 years. He rotated government positions among the various ethnicities that made up Yugoslavia. His system encouraged a national Yugoslavian identity over the specific identity of ethnic groups. In the years following his death in 1980, the system fell apart without his personal authority to settle questions about resource allocation to the republics (Manners, 1996).

During this time Serbian nationalism increased under the direction of Slobadon Milosevic. This rise in nationalistic beliefs happened simultaneously with the fall of communist governments across Eastern Europe. Across the region, independent political parties began to gain power. By 1990, independent parties replaced the disintegrating Communist party (Van Gorp, 1997).

In June 1991, Slovenia was the first Yugoslav republic to announce its independence from Yugoslavia. Soon other republics followed Slovenia's example. Croatia separated in September 1991, Macedonia in February 1992, and Bosnia in April 1992. All that remained of Yugoslavia was Serbia and Montenegro (Organization for Security and Cooperation in Europe, 1998). These secessions made Milosevic's plan for a Serbian-ruled Yugoslavia impossible (Van Gorp, 1997).

War began in Slovenia on June 25, 1991, one day after it declared independence. This war was fought against the Yugoslav army, which was made up primarily of Serbs.

In May 1991, intense fighting began in Croatia, prior to their secession. This battle was only against the Serbs, but the Serbs were supported by the Yugoslav army to prevent Croatia's secession. Fighting began in Bosnia in April 1992. This war was between the Yugoslav army and Bosnia for Bosnia's independence. This war then changed in character to become a civil war. Initially, the fighting was between the Serbs and the allied Muslims and Croats. It then changed into a war among the three factions (Mojzes, 1994).

There is great debate as to the cause of the war in the former Yugoslavia. One theory is that this was a civil war, not unlike the American Civil War during the 1860s. A second theory is that the aggression of the Serbs in order to create a 'Greater Serbia' is to blame. Some believe this war was a continuation of ancient unresolved tribal animosities revived under contemporary circumstances. Another argument claims that the war was caused by former communist bureaucrats attempting to retain power after the fall of the socialist system. Also, this conflict could be blamed on the location of the country. Yugoslavia lies on a collision line of the three great civilizations--Eastern European Orthodoxy, Western European Roman Catholicism, and Asiatic Islam (Mojzes, 1994).

It is difficult to define a singular cause of the war. Each of these arguments contributes to the cause depending on how a person defines the conflict. It would be more accurate to describe this as several wars that are intertwined, rather than one war (Mojzes, 1994). Despite difficulty in determining the cause of the war, the effects of the war on the country and on citizens are easily identifiable.

The war in the former Yugoslavia was the most serious armed conflict in Europe since World War II (Mojzes, 1994). Multiple forms of violence were carried out in the name of 'ethnic cleansing,' defined by the Geneva Convention as "violence committed with specific intent to destroy, in whole or in part, a national, ethnic, or religious group" (Stephens, 1993, p. 13). Mass rape, genocide, and concentration camps were used as tools of ethnic cleansing to remove all non-Serbs from areas of Bosnia and Croatia. These pieces of Bosnia and Croatia forge a link between the Serbian populations in Bosnia, Croatia, and Serbia (Engelberg & Sudetic, 1992). It is important to note that stories of atrocities have surfaced from all sides: Bosnian, Serbian, and Croatian. Innocent blood has been shed by each group involved in this conflict. "All sides have sinned but not all are equally guilty" (Mojzes, 1994, p. 152).

More than 20 rape/death camps and an estimated 90 concentration camps existed in Bosnia alone (Dworkin, 1993). The stories from these camps suggest that the pattern of extermination and expulsion of Bosnian Muslims and Croats from their ancestral lands was not a by-product, but the primary aim of the Serbian campaign (Gutman, 1994). A world that cried "Never again!" after Hitler, pointed out differences, rather than similarities between World War II and the war in the former Yugoslavia (Aspden, 1995).

In the spring of 1992, the district of Prijedor in northwestern Bosnia was ethnically cleansed. This rural area was home to 112,500 people in 1991: 44% were Muslims, 42% Serbs, 6% Croats, and 8% other ethnicities. Today, Prijedor is Serbian territory. According to reliable calculations by the Prijedor Homeland Club in Zagreb, of the 65,000 non-Serbs in Prijedor, 20,000 were murdered, 30,000 were driven away, and

approximately 3,000 were still living in Prijedor in 1994. The rest are unaccounted for (Stiglmeier, 1994). The following passage, a typical description of ethnic cleansing, reconstructs refugees' accounts of how Kozarac, a town in Prijedor, became an ethnically pure area.

In April 1992, important posts and functions were newly filled; Muslims and Croats lost their jobs, and 'reliable' Serbs took over their positions. There was no resistance, because the Muslims and Croats owned virtually no weapons. In May, all telephone communications were disrupted, and the Bosnian Serbs set up roadblocks. . . . 'Cleansing squads,' special units of Serbian army and Serbian irregular units, broke into Muslim houses. 'Suspicious' Muslims were usually killed on the spot. Suspicious meant anyone who had an influential position, who was educated, rich or politically active. Local Serbs handed over lists of appropriate names and promptly took part themselves in the cleansing. All the men whom the Serbs considered potential opponents, as well as a portion of the women, children, and old people, were brought to the internment camps. (Stiglmeier, 1994, p. 87)

According to Stiglmeier (1994) internment camps served three important functions when people were expelled from towns. First, they served as a central collection point for the population prior to their final deportation. Second, able-bodied men or potential leaders who could plan revenge or incite others could be sifted out and killed. Third, these camps made everyone fearful. The true purpose of these camps was to scare people so much that they never would want to return to their homeland again. That is why the camps were full of murder, torture, and rape.

The rapes in the Serbian war of aggression against Bosnia-Herzegovina and Croatia are to everyday rape what the Holocaust was to everyday anti-Semitism: both like it and not like it at all, both continuous and a whole new departure, a unique atrocity yet also a pinnacle moment in something that goes on all the time. (MacKinnon, 1994, p. 74)

Rape occurs in every war. However, the rapes in this war were different, in that rape was an important part of the war strategy. The number of women raped is currently estimated at 20,000 to 50,000 (Seifert, 1994). Most will never be reported due to the social stigma attached to rape (UNHCR, 1993). Muslim women are especially unlikely to report rape due to the ostracism they would face as 'damaged goods' in a society that views women as male property (Allen, 1993). Rape worked as an integral part of ethnic cleansing because it drove women from their country in fear, humiliated them, destroyed families, and forced a generation of 'impure' Muslims or Croats (Morrow, 1993). According to a Serbian soldier testifying in a war crimes trial, the rapes also served a second purpose. He claimed Serbian soldiers were ordered to commit rape in order to boost Serbian soldiers' morale (MacKinnon, 1994).

In 'rape camps' hundreds of imprisoned women faced frequent or sometimes daily rape, deliberate impregnation, and denial of abortions. Women who became pregnant were held until their seventh or eighth month, when an abortion of the unwanted outcome of this act of hatred was no longer possible (Allen, 1993). More than 30,000 women, mostly Muslim, have become pregnant through rape (Doyle, 1993). The impregnation may seem paradoxical to the killing, but according to Serbian logic, the offspring is Serbian. The baby is not even related to the mother (Allen, 1993).

The internment camps are haunting reminders of Nazi Germany. On a visit to the camp in Omarska, Engelberg and Sudetic (1992) witnessed emaciated men peering through barbed wire, their skin stretched drum-tight around their bodies. When asked about the conditions in the camp, only one prisoner responded without solicitation. He

said “Good,” while the men behind him rolled their eyes and shook their heads in disagreement. Although the prisoners denied being beaten, many had fresh wounds and were limping.

These camps also play a role in the Serbian strategy. The reluctance of Bosnians to give up property and flee their homes often weakens after a few weeks in an internment camp. Thousands of Muslims have signed over their goods and property in exchange for their freedom. The property they signed over brought a united Serbia one step closer (Engelberg & Sudetic, 1992).

The History of Refugeeism in the United States

More than three million refugees have entered the United States since the end of World War II. These refugees have come from over 100 countries. The largest groups have come from Cuba, Vietnam, and the former Soviet Union. Early in United States’ history, there was no distinction between immigrants, people in search of a better life in a different country, and refugees, those fleeing persecution. No distinction was needed, because everyone requesting admission was admitted to the United States (Holman, 1996).

The first federal legislation to regulate immigration came in the 1875 with an act barring entry of convicts and prostitutes. In 1882, the Chinese Exclusion Act based eligibility for entry on national origin for the first time. Also, the 1882 Immigration Act charged a head tax of \$.50 per immigrant. These acts mark the beginning of the federal role in immigration, a role that grew significantly in the decades to come (Holman, 1996).

During World War I, legislation was passed to add literacy requirements for immigrants. The exclusion of the Chinese was expanded to include immigrants from most Asian countries. Legislation to follow was the National Origins Quota Act in 1924. This created quotas based on the ethnic ancestry of the United States population in 1920. This meant the larger the proportion of the United States having a particular national origin, the larger the nation's immigration quota would be. This act also limited total immigration to 150,000 persons per year, beginning in 1929 (Holman, 1996).

The Immigration and Nationality Act Amendments of 1965 marked the next revisions to legislation. Exclusions of specific nationalities and the numeric proportions based on national origins of the existing United States population were removed. These were replaced with Eastern and Western Hemisphere limits. The Immigration Act of 1990 further revised the immigration system to allow for a permanent annual level of at least 675,000 beginning in 1995 (Holman, 1996).

Separate legislation had never been passed for refugees, so as Adolph Hitler came to power in Germany and the Jews tried to flee, they were generally denied entry after the quota was full. President Harry Truman attempted to correct for this after World War II by allowing displaced persons to fill 90% of all immigration quotas. From this action, the Displaced Persons Act of 1948 was born. This was the first refugee legislation in the history of the United States (Holman, 1996).

Refugees were redefined by the United States Congress as, "persons fleeing persecution in Communist countries or countries in the Middle East" in the Act of September 11, 1957. This Act also declared that refugee admissions would be addressed

in total separation from immigration admissions. Refugees would also no longer be counted against regular immigration quotas (Holman, 1996, p. 6).

When Fidel Castro came to power in Cuba in January 1959, the United States began a new era in its refugee resettlement. This was the first time in history that the United States was a country of first asylum for a large number of refugees. This refugee flow differed from the earlier refugee flows into the United States. Previously, other countries had provided first asylum and the refugees were screened in overseas camps. Prior to arrival, arrangements could be made so a residence and a job awaited the refugee upon arrival. The Cubans just came. By the end of 1960, there were more than 100,000 Cuban refugees in the Miami area (Holman, 1996).

In order to help state and local agencies deal with the financial stresses of the newly arriving refugees, President Eisenhower established a Cuban Refugee Emergency Center in Miami. Then, President Kennedy allocated money for a wide array of domestic assistance and services for refugees (Holman, 1996).

A similar situation developed in 1975 when the American-supported governments in the countries of the former French Indochina collapsed. Immediately refugees came to the United States. There were nearly 130,000, mostly from Vietnam. Unlike the Cuban program in Miami, the Indochinese refugee program had a nationwide focus. More than 300,000 refugees would eventually settle in all 50 states under this program. Meanwhile, Soviet Jews began to immigrate to the United States as the Soviet Union eased its emigration restrictions. By 1979, funds were provided to assist refugees in the United

States no matter what their country of origin. This aid became available through the Voluntary Agency Matching Grant Program (Holman, 1996).

This would all change again with the Refugee Act of 1980. This act incorporated the United Nations' definition of 'refugee' into the U.S. policy. This act also established an assistance program for all refugee groups in the United States and set goals for a resettlement program. The program removed the requirement that a refugee be from a communist country. The act encourages that the flow of refugees be no greater than 50,000 refugees annually, but the admissions have never fallen that low. The act also created the Office of Refugee Resettlement within the Department of Health and Human Service (Holman, 1996).

The United States has faced many refugee challenges since the legislation changes in 1980. More than 40,000 Haitians and nearly 125,000 Cubans arrived in Florida in late 1980. This again forced the federal government to help the state of Florida. In 1990, Congress passed the Immigration Act of 1990 and created Temporary Protected Status (TPS). This allows temporary refuge for groups of people from a country in which an ongoing armed conflict, environmental disaster, or other extraordinary, but temporary situation prevents its nationals from returning there safely. TPS is granted for 6 to 18 months and can be renewed based on the situation in the country. This was created due to public concern over the situations in Iraq, Haiti, Liberia, Somalia, and Bosnia (Holman, 1996).

Three federal departments of the United States government carry the major responsibilities for refugee resettlement in the U.S. The Department of State manages

the program of initial resettlement. This is carried out under agreements with voluntary agencies. It provides per person funding to the voluntary agencies to settle the refugees around the country. This department is also responsible for the international parts of the refugee policies and programs. The Department of Justice, through the Immigration and Naturalization Service, is primarily responsible for the determination of eligibility of those who apply for refugee status. The Office of Refugee Resettlement is responsible for domestic assistance and services for refugees in the United States (Holman, 1996).

There are specific types of assistance for refugees in the United States authorized by the Refugee Act of 1980. These include full care for minors unaccompanied by a parent or other close relative. This program is always the first to be funded. Cash and medical assistance are provided. Social services may include English-language training and job training. These services are to encourage self-sufficiency among the refugees. Preventive health measures are provided to screen and treat refugees for diseases upon entering the United States (Holman, 1996).

In 1995, the United States admitted about 110,000 refugees. This large number of people is only about two-tenths of one percent of the world's refugees and internally displaced persons. Whether the United States increases or decreases the scope of its refugee programs will not make a large difference in the worldwide refugee situation. To the individual who is either admitted or denied entrance to the United States though, it is extremely important (Holman, 1996).

Refugee Resettlement in Iowa

The history of refugees in Iowa can be traced to a letter from Arthur Crisfield. Crisfield, a U.S. government employee, who had worked in Southeast Asia, wrote a letter to 30 United States governors asking that one state open its doors to 250 Tai Dam families originally from North Vietnam. The Tai Dam were closely tied to the French Government and thus labeled 'enemies of the people' by the Communist Democratic Republic of North Vietnam. Thus, they were forced to flee the region for their safety. Crisfield requested the group be resettled en-mass because they were "the last group of Tai Dam still able to preserve their songs, their dress, and their traditions within the mainstream of the free world" (Bureau of Refugee Services [BRS]; 1996, p. 5). Early in July 1975, one governor responded to Crisfield, Iowa's Governor Robert Ray (BRS, 1996).

The Governor's Task Force for Indochinese Resettlement was created in July 1975. Governor Ray insisted that the program would be successful because available resources would be channeled through the employment service instead of the welfare agencies. The philosophy was to promote work over welfare (BRS, 1996). The Governor's Task Force is now known as the Iowa Department of Human Services, Bureau of Refugee Services. The BRS is one of the 12 national voluntary refugee resettlement agencies engaged in a cooperative agreement with the United States Department of State to provide for the reception and initial placement of refugees (BRS, 1993). Iowa is unique in that it is the only state that acts as a resettlement agency. Most states contract

with a national religious group, such as Lutheran Social Service, to coordinate resettlement (Shaw, 1995).

Since 1975, Iowa has welcomed more than 18,000 refugees (BRS, 1997). These refugees have come from many corners of the world, including Vietnam, Laos, Cambodia, Poland, Hungary, Romania, Bosnia, Burma, the Sudan, and others. The refugees are resettled throughout the state with the largest populations in Black Hawk, Buena Vista, Linn, Polk, Scott, and Woodbury counties.

Bosnian Refugees in Waterloo, Iowa

The first Bosnian refugees to Waterloo, Iowa arrived in December 1996 (Willmsen & Stanton, 1996). Over the past 19 months, approximately 2,300 Bosnians have settled in Waterloo. This number is expected to increase by more than 2,000 by the year 2000 (P. Woodsen, personal communication, July 2, 1998). A large number of the Bosnian refugees are Muslim, and come to Waterloo from Velika Kladusha, a northwest Bosnian town of 70,000 people. Similar to Waterloo, the town was home to a large meat packing plant, according to Pelajida Woodsen, Director of Refugee Programs for Lutheran Social Service in Waterloo (personal communication, July 2, 1998).

Iowa Beef Processing, Inc. hired 47 of the first 67 Bosnians in Waterloo to work at its Waterloo meat packing plant (Willmsen & Stanton, 1996). Presently, about 600 Bosnians work there. Others are finding jobs in areas more compatible with their prior work experience and education (P. Woodsen, personal communication, July 2, 1998). For example, a class was recently held at Hawkeye Community College to help Bosnians secure commercial driver's licenses. The BRS learned that many of the Bosnian refugees

were truck drivers in Bosnia. All that prevented them from continuing that career in Iowa was learning the rules of the road and some language skills. All of the class participants passed the course (Ericson, 1998; P. Woodsen, personal communication, July 2, 1998).

Every Wednesday new primary and secondary refugees attend an intake process at Waterloo's Pinecrest Building. There they meet with Lutheran Social Service, the Department of Human Services, the Black Hawk County Health Department, Social Security, Waterloo Community Schools, and People's Community Health Clinic. It is during this process that the refugees are tested for tuberculosis and schedule appointments with People's Clinic (Graves, 1997).

The Black Hawk County Health Department has identified dental health as the number one acute care problem among the Bosnian children. Ninety percent of the children screened have significant dental problems, requiring major dental work. The dental work is being paid for with money from the state's Child Health grant. County Relief and local dentists are paying for the rest of the bill. Preventing the spread of communicable disease is the county's top health priority for the population-at-large. Currently tuberculosis is the main concern (Schmidt, 1997).

Upon arrival, all Bosnian children and adolescents initially attend classes at Bunker School of Technology to determine their level of education and English proficiency. The Waterloo Community School District offers English as a Second Language (ESL) classes to students who are learning English. In two Waterloo schools, Elk Run Elementary and Jewitt Elementary, at least 25% of the students are enrolled in

ESL classes. As students are moved into the mainstream classroom, interpreters are provided to help students with what they do not understand (Stanton, 1998; P. Woodsen, personal communication, July 2, 1998). Many of the Bosnian students have made smooth, successful transitions into the Waterloo Community School District. In fact, Bosnian students made up 13% of the honor roll at West Middle School this spring (Nick, 1998).

Many of the Bosnian refugees arrive in Waterloo with some English skills. About 25% speak enough English to communicate. To improve this, classes are held often to teach English skills. This will benefit the refugees not only in interactions with the English-speaking community, but also in their job search (P. Woodsen, personal communication, July 2, 1998).

Schools, health clinics, and social service agencies employ Bosnian refugee paraprofessionals as interpreters and assistants to enhance communication and program success. Some Waterloo residents are taking proactive steps and learning Bosnian. Hawkeye Community College offers a six-week course in the Serbo-Croatian language. The class is so popular there is a waiting list to enroll (Ericson, 1998).

Many agencies are reaching out to help the Bosnians. Lutheran Social Service is the lead agency organizing aid to the refugees. Many churches, civic organizations, and families have helped by donating clothes, furniture, and food. Others donate their time to help the Bosnians become familiar with Waterloo. Refugees in need of additional assistance can apply for food stamps, the Family Investment Plan (FIP), and Medicaid (P. Woodsen, personal communication, July 2, 1998).

The Need for Rapid Mental Health Assessment
for Bosnian Refugees in Waterloo, Iowa

Rapid assessment procedures in mental health for the Bosnian refugee population in Waterloo, Iowa, would be beneficial in a variety of ways. First, the Black Hawk-Grundy Mental Health Center, Inc. which is responsible for mental health care for this population needs to have prevalence data in order to better serve the population. Based on this information, the Center could add staff, facilities, or resources to accommodate needs. Also, baseline information is important to document needs in order to secure outside funding.

Secondly, the rapid assessment of mental health problems is beneficial to the Bosnian population. Those who are suffering from mental illness and at this time are untreated or undiagnosed will not adapt to their new community as quickly or successfully as they could. The family of an afflicted person is also under added stress.

Third, this is an opportunity for the Black Hawk County Health Department to lead the way among small communities with large Bosnian refugee influxes. Refugees have been described as seeing the present and the future in only the light of the past. By assessing mental health needs, the Black Hawk County Health Department can help refugees see their past, present, and future in a balanced perspective.

To determine prevalence of PTSD and depression, help secure funding for future mental health services, and set an example for other counties, it is important to develop rapid assessment procedures for mental health. This quick and program-based

information will allow for planning and growth opportunities for the future of the Black Hawk County refugee program.

CHAPTER 3

METHODS

The purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in adult Bosnian refugee population in Waterloo, Iowa.

Method of Questionnaire Development

Tom O'Rourke, Director of Public Health for Black Hawk County, Waterloo, Iowa, was contacted about the feasibility of adding mental health questions to the health histories that are collected during the county's weekly refugee intake session. This session was chosen as a prime opportunity to collect this information because all refugees entering Black Hawk County must attend this session in order to register for local assistance. Thus, it is assumed 100% of the future refugee population could be accessed through these weekly sessions.

With O'Rourke's approval, the researcher began to collect information on refugee health, the refugee situation worldwide, and the refugee situation in Bosnia. These topics led the researcher to literature on post-traumatic stress disorder, clinical depression, and acculturation stress among refugees.

From the literature, it was determined that the most likely mental health problems that would be seen in the refugees from the former Yugoslavia were post-traumatic stress disorder and depression. Dr. Mary Fabri, Director of Refugee Mental Health Training for Chicago Health Outreach, Inc. confirmed this finding. Dr. Fabri also supplied a list of symptoms that are indicators of mental health problems in Bosnian refugees (see

Appendix A). Using the list of symptoms from Dr. Fabri and information from the literature review, common symptoms of the two illnesses were developed into a yes and no format questionnaire.

The 34-item questionnaire (see Appendix B) divides the responses into five sections: demographics, symptoms of Criterion B of PTSD, symptoms of Criterion C of PTSD, symptoms of Criterion D of PTSD, and symptoms of depression. The particular symptoms were chosen based on their commonality and the ability to be answered in a yes and no format. The time frame of one month was chosen because symptoms must persist for one month to be diagnosed as PTSD.

Demographic questions were included to correlate the presence or absence of symptoms to specific traits such as age or gender. Specific information, such as the ability to speak English is linked to acculturation stress, and thus may play a role in the diagnosis of depression. The demographic information will allow for targeting the age group or gender in need of the most help. This will also help with the planning and promotion of mental health care.

The length of the questionnaire (see Appendix B) was determined by the Black Hawk County Health Department's desire for the survey to consume less than 10 minutes and to fit on one piece of paper. With those limitations the questionnaire was limited to the most specific questions possible.

A signed informed consent release was not added to the survey due to the highly sensitive nature of the data. The opening paragraph of the questionnaire states the purpose of the data collection and assures confidentiality of information. This

information will be collected under the auspices of the Black Hawk County Health Department, but analyzed and stored at the University of Northern Iowa. The researcher has facilities to store the data in a locked place and shred the data after analysis.

The questionnaire (see Appendix B) was sight validated by Dr. Tom Eachus, psychiatrist at the Black Hawk-Grundy Mental Health Center, Inc. Dr. Eachus has seen the Bosnian refugees previously referred for counseling by the People's Community Health Clinic, where all incoming refugees are scheduled for physicals within their first week in Black Hawk County. The questionnaire was also sight validated by Dr. Michele Yehieli, Assistant Professor of Health Education at the University of Northern Iowa. She is a specialist in refugee health and has significant international experience with refugees.

Description of Individual Questions

The following chart describes each question and explains its purpose in the questionnaire.

<u>QUESTION</u>	<u>DESCRIPTION</u>	<u>UTILIZATION</u>
1	Gender	Demographic for Correlation and Linked to Acculturation Stress #
2	Age at Last Birthday	Demographic for Correlation and Linked to Acculturation Stress #
3	Occupation in Bosnia	Linked to Acculturation Stress #
4	Time Since Client Left Bosnia	Demographic for Correlation
5-9	Places Lived Since Leaving Home	Demographic for Correlation
10	English Proficiency	Linked to Acculturation Stress #
11	Has a Friend to Confide In	Linked to Acculturation Stress #

<u>QUESTION</u>	<u>DESCRIPTION</u>	<u>UTILIZATION</u>
12	Is Awakened by Dreams	Symptoms of Criterion B of PTSD*
13	Is Unable to Sleep/Return to Sleep	Symptoms of Criterion D of PTSD*
14	Has Intrusive Thoughts/Memories	Symptoms of Criterion B of PTSD*
15	Argues/Yells More	Symptoms of Criterion D of PTSD*
16	Wants to be Alone More	Symptoms of Criterion C of PTSD*
17	Avoids Contact with Others	Symptoms of Criterion C of PTSD*
18	Is Numb To Feelings	Symptoms of Criterion C of PTSD*
19	Is More Forgetful	Symptoms of Criterion C of PTSD*
20	Misplaces Things	Symptoms of Criterion C of PTSD*
21	Is Unable to Fall Asleep	Symptoms of Criterion D of PTSD*
22	Feels Heart Pounding	Symptoms of Criterion D of PTSD*
23	Feels He/She is Choking	Symptoms of Criterion D of PTSD*
24	Is Unable to Pay Attention	Symptoms of Criterion D of PTSD*
25	Has Heard Name Called	Symptoms of Criterion D of PTSD*
26	Has Lost Excess Weight	Symptoms of Clinical Depression°
27	Has Gained Excess Weight	Symptoms of Clinical Depression°
28	Feels Sad All the Time	Symptoms of Clinical Depression°
29	Feels Helpless/Hopeless	Symptoms of Clinical Depression°
30	Has Thought About Suicide	Symptoms of Clinical Depression°
31	Has Not Gotten out of Bed	Symptoms of Clinical Depression°
32	Has Not Dressed for the Day	Symptoms of Clinical Depression°
33	Information Source	Question of interest to Black Hawk County Health Department regarding whether or not refugees are aware of available services.
34	Location of Family	Linked to Acculturation Stress #

(Haines, 1996)

* (American Psychiatric Association, 1994)

° (U.S. Department of Health and Human Services, 1991)

CHAPTER 4

RESULTS

The purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in the adult Bosnian refugee population in Waterloo, Iowa.

The result of this study is a questionnaire (see Appendix B) to be used by the Black Hawk County Health Department and other local health departments in the state challenged with an influx of Bosnian refugees. This questionnaire should be implemented over the course of the refugee influx to determine prevalence of symptoms and then to monitor changes in symptoms among incoming refugees. These data should be reanalyzed every three months to monitor possible changes.

This questionnaire is to be distributed during the weekly intake session at the Black Hawk County Health Department. A station marked “Black Hawk County Health Department” will be added to the list of tables the refugees must visit.

At least one person should be working at the table. This person will pass out the questionnaires and provide pens or pencils. The preference would be to have someone at the table who speaks Bosnian, but is not a member of the Bosnian refugee community. The ability to ask a stranger, rather than an acquaintance, a question about mental health would contribute to privacy while responding to the questionnaire. The limited number of available interpreters may make that difficult. The person at the table would at least need to be able to say certain necessary phrases, such as “Please, fill out this

questionnaire.” and “Thank you.” There are always a few available interpreters in the room during the intake session who can be summoned for help if it is needed.

The person distributing the questionnaire should be very familiar with the questionnaire, so that if a question arises, he/she can explain the meaning of the question to the respondent.

The chairs should be removed from the front of the table to discourage respondents from sitting at the table to fill out the questionnaire. At all other stations the respondents sit face to face with the service provider. At this station, privacy should be offered. Many empty tables are available during the weekly intake session. These can be utilized for the respondents to spread out. This is important to supply some privacy and quiet. Due to the limited number of refugees per intake session separate booths or screens are not needed.

The questionnaires need to be collected from the respondents in a manner that shows respect and privacy. The person collecting them should put them in a box without looking at them. If a person declines to fill out the questionnaire, the person at the table should not argue, just take back the questionnaire.

Community-based studies present a lifetime prevalence for PTSD ranging from 1% to 14%, depending upon the sample population. Prevalence rates ranging from 3% to 58% were found in at-risk individuals, such as combat veterans and victims of a natural disaster (APA, 1997). According to the U.S. Department of Health and Human Services (1991) in any six-month period, approximately 6.6% of women and 3.5% of men in the United States will have a depressive disorder. Thus, if the questionnaire results show a

substantial increase above these figures, the Black Hawk County Health Department will know that there is a significant proportion of the adult Bosnian refugee population with symptoms of PTSD and depression. In this event, funding should be secured to provide appropriate counseling and treatment to those in need.

The counseling provided needs to be bilingual and bicultural. This means the interpreter needs to not only know the language of the refugee, but also the culture. This is important for both spoken and written communication. Merely translating material into the Bosnian language does not make it understandable, due to cultural differences and contexts.

Mental health professionals may need to be trained to work through an interpreter. This may be difficult for some as it requires spending a great deal of time waiting for a response.

Counselors need to be aware that stigma is often attached to having a mental disorder in other cultures. Mental health professionals need to reassure their refugee clients that their reactions are ordinary reactions to extraordinary circumstances. It is also important to explain to the client how the mental health system works in the United States and discuss confidentiality laws. Because of these issues, rapport may be difficult to establish with clients. This may be especially true if clients have a mistrust of authority or government.

All people working with the refugees should be knowledgeable of recent Yugoslavian history and the situations that brought these refugees to Waterloo, Iowa. This may increase workers' understanding and sensitivity.

It is important that medical workers be trained to recognize the psychological effects of torture and trauma and to recognize somatic complaints that have psychosomatic causes. Many refugees present with somatic illness, that is actually psychologically-related.

Finally, refugees need to be treated with respect and welcomed to the community. The refugee intake process should be one that empowers the refugees. Many are coming from oppressive, disempowering situations. Their first contact with the Black Hawk County Health Department should be one that allows them to have as much control as possible in the situation.

CHAPTER 5

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

The purpose of this study was to develop rapid assessment protocols to evaluate the prevalence of common symptoms of clinical depression and post-traumatic stress disorder in the adult Bosnian refugee population in Waterloo, Iowa. The outcome of this study was the development of a questionnaire (see Appendix B) and protocols for its administration. The questionnaire measures the prevalence of symptoms of PTSD and depression and collects demographic data.

Rapid assessment procedures in mental health for the adult Bosnian refugee population in Waterloo, Iowa, will be beneficial in a variety of ways. First, the Black Hawk-Grundy Mental Health Center, Inc. which is responsible for mental health care for this population needs to have prevalence data in order to better serve the population. Based on this information, the Center could add staff, facilities, or resources to accommodate needs. Also, baseline information is important to document needs in order to secure outside funding.

Secondly, the rapid assessment of mental health problems is beneficial to the Bosnian population. Those who are suffering from mental illness and at this time are untreated or undiagnosed will not adapt to their new community as quickly or successfully as they could. The family of an afflicted person is also under added stress.

Third, this is an opportunity for the Black Hawk County Health Department to lead the way among small communities with large Bosnian refugee influxes. There is a

lack of information available in the English language on the topic of rapid mental health assessment. This allows the Black Hawk County Health Department to serve as a model to the state, nation, and possibly the world as a testing ground for rapid mental health assessments. This quick and program-based information will allow for planning and growth opportunities for the future of the Black Hawk County refugee program.

Discussion

The lack of literature on rapid mental health assessment procedures suggests that this technique has not been utilized or information about utilization has not been published. This may be the case for several reasons. First, refugeeism is not a science. Although refugee groups encounter the same adaptational difficulties and tend to develop similar problems (Ben-Porath, 1991), each new group of refugees to the United States has been treated as a unique crisis rather than an ongoing flow of refugees (Gordon, 1996). This framework only allows for reactive work. Proactive planning is necessary in order to implement tools such as this questionnaire.

A second reason there is little information on rapid mental health assessment is the lack of collaboration between the field of psychiatry and the field of public health. Historically, what may be known to the clinician is not being utilized by the public health practitioner. This tool is an effort to bridge that gap.

This tool should be translated into the Bosnian language by a native Bosnian translator to ensure cultural transference of meaning.

This tool should be pretested prior to mass use. It should be pretested on a small number of incoming refugees to see initial responses. It also should be pretested with a

group of people who speak Bosnian and English to determine if the context of the question is the same in the translated questionnaire.

Many ethical issues arise in the mental health field with the use of a questionnaire such as this. While responding to the questionnaire and contemplating these symptoms, some negative emotions may surface in the respondent. Answering these questions may trigger an emotional response from some respondents. This issue was kept in mind during the development of the questionnaire. This is the reason the questions ask about symptoms of PTSD and depression and not the presence of traumatic experiences.

A second ethical question is also present. If this questionnaire has the capacity to create some negative emotions in respondents, do we have adequate resources to meet their needs? At this point, Black Hawk-Grundy Mental Health Center, Inc. is only seeing the clients with greatest need and could not accommodate a great increase in numbers of clients. The justification for this use of this questionnaire without adequate counseling services is that in order to supply adequate mental health services in the future, data are needed. If a limited number of respondents do have an extreme emotional reaction, counseling can be provided. After the field test, an estimate of how many respondents will have negative emotional reactions can be made. To help alleviate some of the negative emotions created, it is suggested that a brochure be given to all respondents on how to relieve stress, recreational activities in the local area, and telephone numbers for emergency referrals.

Considering the highly private nature of this data, underreporting is expected. This does not invalidate the data. The Black Hawk County Health Department can

assume that the prevalence of symptoms is higher than what is reported through this questionnaire.

People who are illiterate will not be able to accurately complete the questionnaire. In the future, it would be appropriate to have a way for respondents to participate in the questionnaire orally. This prevalence of illiteracy among this group is low, but information about services will need to be distributed in multiple forms in order to reach the illiterate. Radio advertisements and announcements at community activities will need to be made in order to reach those that do cannot read the newspaper or flyers.

Recommendations

Based on this study the following recommendations are made:

1. Black Hawk County Health Department and other county health departments challenged with an influx of Bosnian refugees should implement use of this questionnaire over the course of refugee influx to determine prevalence of symptoms of PTSD and depression and to monitor changes in symptoms among incoming refugees.
2. Local agencies working with this population should develop a shared information network to allow caseworkers/clinicians immediate access to information about clients from all other caseworkers/clinicians working with the client.
3. English-language programs and job skill programs for the refugees should be continuously supported.
4. A separate tool should be developed to determine the prevalence of post-traumatic stress disorder in children and in the elderly. Age-appropriate and culturally-appropriate programming should be developed if necessary.

5. Bosnian-language programs should be available on a regular basis to English speakers in the Waterloo area.

6. The University of Northern Iowa should recruit and finance the education of at least three native-Bosnian speakers in the Mental Health Counseling program to fill the void of bilingual-bicultural counselors.

REFERENCES

- Ackerman, L. K. (1997). Health problems of refugees. Journal of the American Board of Family Practice, 10(5), 337-348.
- Allen, B. (1993, April 4). Unspeakable: When rape become a weapon of genocide. The Houston Chronicle, p. O5.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.
- Aspden, P. (1995, July 29). Whatever happened to "never again"? London Financial Times, p. xvi.
- Ben-Porath, J. S. (1991). The psycho-social adjustment. In U.S. Department of Health and Human Services, Mental health services for refugees (pp. 1-23). Rockville, MD: U.S. Government Printing Office.
- Berry, J. W. (1991). Managing the process of acculturation for problem prevention. In U.S. Department of Health and Human Services, Mental health services for refugees (pp. 189-204). Rockville, MD: U.S. Government Printing Office.
- Bureau of Refugee Services. (1993). Introduction to the Bureau of Refugee Services [Brochure]. Des Moines, IA: Iowa Department of Human Services.
- Bureau of Refugee Services. (1996). A chronological history of Iowa's refugee program 1975-1995 [Brochure]. Des Moines, IA: Iowa Department of Human Services.
- Bureau of Refugee Services. (1997). Statistical report: October 1, 1995-September 30, 1997 [Brochure]. Des Moines, IA: Iowa Department of Human Services.
- Doyle, L. (1993, January 6). Victims of cold, calculated cruelty. The Independent, p. 7.
- Dworkin, A. (1993, September 5). The real pornography of a brutal war against women. Los Angeles Times, p. M2.
- Engelberg, S., & Sudetic, C. (1992, August 16). Conflict in the Balkans: In enemy hands. The New York Times, pp. A1, A14.
- Ericson, Jon. (1998, March 25). With HCC help, Bosnians will keep on trucking. Waterloo-Cedar Falls Courier, C1.

- Ericson, Jon. (1998, July 7). Bosnian youth helping residents learn the language. Waterloo-Cedar Falls Courier, C1, C2.
- Glass, R. I., Nieburg, P., Cates, W., Davis, C., Russbach, R., Peel, S., Nothdurft, H., & Turnbull, R. (1980). Rapid assessment of health status and preventive-medicine needs of newly arrived Kampuchean refugees, Sa Kaeo, Thailand. The Lancet, 8173, 868-872.
- Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. American Psychologist, 46(6), 642-648.
- Gonsalves, C. J. (1990). The psychological effects of political repression on Chilean exiles in the U.S. American Journal of Orthopsychiatry, 60(1), 143-153.
- Gordon, L. W. (1996). The origins and initial resettlement patterns of refugees in the United States. In D. W. Haines (Ed.), Refugees in America in the 1990s: A reference handbook (pp. 331-354). London: Greenwood Press.
- Graves, B. (1997, August 28). Bosnian population passes 1,000 in area. Waterloo-Cedar Falls Courier, A1, A8.
- Guha-Sapir, D. (1991). Rapid assessment of health needs in mass emergencies: Review of current concepts and methods. World Health Statistics Quarterly, 44(3), 171-181.
- Gutman, R. (1994). Foreword. In A. Stinglmayer (Ed.), Mass rape: The war against women in Bosnia-Herzegovina (pp. iv-xiii). Lincoln: University of Nebraska Press.
- Haines, D. W. (1996). Patterns in refugee resettlement and adaptation. In D. W. Haines (Ed.), Refugees in America in the 1990s: A reference handbook (pp. 28-59). London: Greenwood Press.
- Hanks, G. W., Trueman, T., House, M. S., Evans, P. J. D., & Ancill, R. J. (1985). Depression and anxiety in pain clinic patients: Rapid assessment by microcomputer. Anesthesia, 40(7), 676-679.
- Holman, P. A. (1996). Refugee resettlement in the United States. In D. W. Haines (Ed.), Refugees in America in the 1990s: A reference handbook (pp. 3-27). London: Greenwood Press.

- Jensen, S. B., Schaumburg, E., Leroy, B., Larsen, O., & Thorup, M. (1989). Psychiatric care of refugees exposed to organized violence: A comparative study of refugees and immigrants in Frederiksborg County, Denmark. Acta Psychiatry Scandinavia, 1989(80), 125-131.
- Kinzie, J. D., & Boehnlein, J. K. (1993). Psychotherapy of the victims of massive violence: Countertransference and ethical issues. American Journal of Psychotherapy, 47(1), 90-103.
- Kismaric, C. (1989). Forced out: The agony of the refugee in our time. New York: Random House.
- Lazare, A. (1976). The psychiatric examination in the walk-in clinic. Archives of General Psychiatry, 33(1), 96-102.
- Locke, C. J., Southwick, K., McCloskey, L. A., & Fernandez-Esquer, M. E. (1996). The psychological and medical sequelae of war in Central American refugee mothers and children. Archives of Pediatric and Adolescent Medicine, 150, 822-828.
- Loescher, G., & Loescher, A. (1994). The global refugee crisis. Santa Barbara, CA: ABC-CLIO.
- MacKinnon, C. (1994). Turning rape into pornography. In A. Stinglmayer (Ed.), Mass rape: The war against women in Bosnia-Herzegovina (pp. 73-81). Lincoln: University of Nebraska Press.
- Manners, L. (1996). Short History. [On-line], Available: http://www.bosnet.org/bosnia/culture/s_history.html
- Mayaud, P., Msuya, W., Todd, J., Kaatano, G., West, B., Begkoyian, G., Grosskurth, H., & Mabey, D. (1997). STD rapid assessment in Rwandan refugee camps in Tanzania. Genitourinary Medicine, 73(1), 33-38.
- McGorry, P. (1995). Working with survivors of torture and trauma: The Victorian Foundation for Survivors of Torture in perspective. Australian and New Zealand Journal of Psychiatry, 1995(29), 463-472.
- Mojzes, P. (1994). Yugoslavian inferno: Ethnoreligious warfare in the Balkans. New York: Continuum.
- Murrow, L. (1993, February 22). Unspeakable. Time, 141(8), 48-51.

- Nick, S. (1998, July 7). Many Bosnian students excelling in classroom. Waterloo-Cedar Falls Courier, C1.
- Organization for Security and Cooperation in Europe. (1998, April 13). A brief history of Yugoslavia. [On-line], Available: <http://www.oscebih.org/hisn.html>
- Sack, W. H., Clarke, G. N., & Seeley, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. Child Development, 67(1), 107-116.
- Sandler, R. H., & Jones, T. C. (1987). Medical care of refugees. New York: Oxford University Press.
- Schmidt, S. (1997, May 1). Bosnian children in dire need of expensive dental care. Waterloo-Cedar Falls Courier, A1, A5.
- Scrimshaw, S. C. M., & Hurtado, E. (1987). Rapid assessment procedures for nutrition and primary health care: Anthropological approaches to improving programme effectiveness. Los Angeles: UCLA Latin American Center Publications.
- Seifert, R. (1994). War and rape. In A. Stinglmayer (Ed.), Mass rape: The war against women in Bosnia-Herzegovina (pp. 54-72). Lincoln: University of Nebraska Press.
- Shaw, B. (1995, September 1). Bosnians build new lives in the state. The Des Moines Register, A1.
- Stanton, J. (1998, January 25). Schools seek federal five-year grant to teach immigrants. Waterloo-Cedar Falls Courier, A4.
- Stephens, B. (1993). Women and the atrocities of war. Human Rights, 20(3), 12-15.
- Stinglmayer, A. (1994). The rapes in Bosnia-Herzegovina. In A. Stinglmayer (Ed.), Mass rape: The war against women in Bosnia-Herzegovina (pp. 82-169). Lincoln: University of Nebraska Press.
- Tran, T. (1993). Psychological traumas and depression in a sample of Vietnamese people in the United States. Health and Social Work, 18(3), 184-194.
- United Nations. (1996). World population monitoring 1993 with a special report on refugees. New York: Author.

- United Nations Development Programme. (1998, July 1). Role of Rapid Assessment Procedures [On-line], Available: <http://www.undp.org/popin/confcon/rapid/raprept.htm>
- United Nations High Commissioner for Refugees. (1993). The state of the world's refugees: The challenge of protection. New York: Penguin Books.
- United Nations High Commissioner for Refugees. (1996). UNHCR [On-line], Available: <http://www.unhcr.ch/>
- U.S. Committee for Refugees. (1996). World refugee survey. New York: Immigration and Refugee Services of America.
- U.S. Department of Health and Human Services. (1991). Information about D/ART and depression [Brochure]. Rockville, MD: Public Health Service.
- van der Veer, G. (1992). Counselling and therapy with refugees. New York: John Wiley and Sons.
- Van Gorp, S. (1997). Making coffee, baking bread, and bridging the gaps: An ethnography of Bosnian women in the refugee community of Des Moines, Iowa. Unpublished master's thesis, University of Northern Iowa, Cedar Falls, Iowa.
- Weine, S. M., Becker, D. F., McGlashan, T. H., Laub, D., Lazrove, S., Vojvoda, D., & Hyman, L. (1995). Psychiatric consequences of "Ethnic Cleansing": Clinical assessments and trauma testimonies of newly resettled Bosnian refugees. American Journal of Psychiatry, 152(4), 536-542.
- Westermeyer, J. (1995). Cross-cultural care for PTSD. In G. S. Everly & J. M. Lating (Ed.), Psychotraumatology: Key papers and core concepts in post-traumatic stress (pp. 377-397). New York: Plenum Press.
- Willmsen, C., & Stanton, J. (1996, December 22). Waterloo gives Bosnians refuge. Waterloo-Cedar Falls Courier, A1, A9.

APPENDIX A
SYMPTOM LIST FROM DR. MARY FABRI

This is the English translation of a brochure that is given to Bosnian refugees
by Chicago Health Outreach, Inc.

Now that you are resettled in the United States, you may have many life circumstances to deal with. You have left your home and perhaps family members. You have left your country where you were familiar with the language, customs, and traditions. Even though you may feel that it was the best thing for you to leave and come to the United States as a refugee, it will be very normal for you to have a range of feelings about the experience.

Sometimes a refugee comes to the United States with the dream of a new life. One that will be safer and will provide all of their basic needs. Sometimes a refugee has dreams of a better and richer life than the one in their homeland. Sometimes a refugee believes that life will just be easier in the United States. Resettlement as a refugee is a very difficult transition time. Many adjustments and adaptations are needed to accommodate new living situations. Sometimes the realities of resettlement result in an assortment of feelings, for example: disappointment, sadness, anger, loneliness, fear, confusion, and sometimes despair. You may have experienced some or all of these feelings or perhaps some different feelings.

Feelings are a normal part of the human experience. Sometimes, however, feelings can be uncomfortable or confusing. Often feelings can be overwhelming and difficult to name. It is also common not to want to talk with others about these overwhelming feelings, not wanting to burden others, not wanting to be misunderstood, not wanting to complain.

The mental health care system in the United States may be very different from what you are familiar with in your homeland. In many countries, receiving help for

mental health reasons means that you are “crazy” or have a chronic mental illness. While it is true that the United States provides many services for chronic mental illness, it is also true, that there is help for people who are having emotional reactions to difficult situations in their life. These acute conditions are often helped with temporary use of medication and/or counseling.

If you are aware of having a pre-existing mental illness that required hospitalization(s) and/or medication in the past, please inform the physician that sees you for the health screening exam. If you have medicine bottles or reports from doctors it is important to share them with the doctor even though they are not in the English language. A trained bilingual health care interpreter can help the doctor with what it says. It is important that your treatment be continued if you have a chronic mental illness.

Most refugees have never received any help from a mental health professional before. Most people have been able to turn to a close family member, a trusted friend, or a respected community or religious person in times of need for advice or council. Coming to the United States as a refugee often takes away the person you would have normally turned to when you needed someone to talk with.

If you are having a difficult time with some part of your life as a refugee, it is important to share this with your caseworker or with the medical doctor that does your health screening. If you can name the adjustment problems and emotional upsets you may be having and then tell someone you can get help to make them better. With help, you may be able to solve these problems before they get worse or sooner than if you tried to solve them alone.

The experience of being a refugee can cause a range of different feelings. Once you get settled, you may start to become aware of these feelings, if you are not already aware of them. Often there are physical symptoms and behavior changes that you may notice. You may be having trouble doing the things you would normally do through a day. These changes can be signs to pay attention to. Some of these changes may be:

Sleep Problems:

- not being able to fall asleep at night
- not being able to sleep through the night until morning
- not being able to go back to sleep after waking up at night
- being awakened at night by bad dreams or nightmares

Appetite problems

- not feeling hungry
- only eating if someone makes sure that you do
- losing weight, noticing that your clothes are too loose,

or some people

- feel hungry all of the time
- eat more food than you need
- gain weight beyond your usual weight, noticing that your clothes are too tight and don't fit you anymore

Problems with your nerves

- feeling shakiness inside
- having body tremors
- sweating a lot
- your heart pounds so that you can feel it in your chest
- feeling like you are choking
- feeling like you cannot get enough air to breathe
- feeling like there is something crawling on your skin
- feeling like you are going to die

Problems with your mood

- feeling sad all the time
- having crying spells

feeling very irritable
 arguing and yelling more with the people you see everyday
 wanting to be alone more than you used to
 avoiding contact with other people more than you used to
 sighing a lot
 feeling numb, like you do not have feelings anymore
 feeling hopeless, like nothing will ever change or get better
 feeling helpless, like there is nothing you or anyone can do to help your
 situation to get better
 wishing that you would die
 thinking about ways to end your life
 not getting out of bed in the morning to do the things you need to do
 not getting dressed for the day
 not feeling the will to get simple daily tasks completed

Problems with the way you are thinking

being forgetful
 misplacing things
 forgetting to finish the things that you start
 not being able to remember familiar information
 not being able to complete simple and/or familiar tasks because you
 cannot pay attention to what you are doing
 not being able to read, watch TV, or listen to the radio because you cannot
 pay attention or sit still
 having intrusive thoughts and memories that you cannot control
 hearing a knock on the door and when you check, no one is there
 hearing someone call your name, but when you look, no one is there
 having time pass without being aware of how you spent that time
 feeling confused about where you are

If you or a family member is experiencing any or all of these problems, please
 share this information with your caseworker or doctor. These feelings and reactions are
 all normal and possible reactions to the trauma you have lived through in your homeland,
 in your passage to come to the United States as a refugee, and/or in your resettlement
 process here. You may no longer have the person you would have turned to talk about
 these things with. In the United States, in Illinois, there are programs that are especially

designed to help refugees with these kinds of feelings and reactions. They are staffed by people who have been trained to understand your customs and beliefs. You may have survived a lot of suffering and may be continuing to feel that suffering. If you are experiencing any of the described changes in your ability to get through a day, letting someone know, may help you to get some assistance so that you can feel better sooner.

APPENDIX B
QUESTIONNAIRE

**Black Hawk County Health Department
Bosnian Mental Health Study**

Hi, my name is _____. I work for the Black Hawk County Health Department. The people at the Health Department know that resettling in the United States can be a very stressful experience. You have possibly left your family and your home and your homeland. The following questions are meant to determine how you are handling that stress. You may refuse to answer any question. Participation in this study is voluntary. I will not use your name or any other identifying information in any way. Your responses are completely confidential. I know some of these questions are very personal. The feelings you may be experiencing are often very normal responses to extraordinary situations. Your honest responses will help the Black Hawk County Health Department better serve your needs.

1. (01)male____ (02)female_____
2. How old were you on your last birthday? _____
3. Occupation in Bosnia_____
4. How long ago did you leave your home in Bosnia?
(in years and months, 00 being less than one month ago)_____

Between leaving your home in Bosnia and arriving in Waterloo, Iowa, have you...

5. (01) yes____ (02) no____ lived elsewhere in Bosnia?
6. (01) yes____ (02) no____ lived in a concentration camp or prison?
7. (01) yes____ (02) no____ lived in a refugee camp?
8. (01) yes____ (02) no____ lived in another European country?
9. (01) yes____ (02) no____ lived in another city or town in the United States?
10. How many months of English class have you taken?
(record in months, 00 less than one month) _____
11. Do you have a friend that you feel you can talk to about any problems you may have?
01) yes____ (02) no_____

In the past month have you been.....

12. (01) yes____ (02) no____ awakened at night by bad dreams or nightmares?
13. (01) yes____ (02) no____ unable to sleep through the night or unable to return to sleep after waking in the night?

14. (01) yes____ (02) no____ had intrusive thoughts or bad memories that you could not control?
15. (01) yes____ (02) no____ argued and yelled more than usual with the people you see every day?

In the past month have you....

16. (01) yes____ (02) no____ wanted to be alone more than you used to?
17. (01) yes____ (02) no____ avoided contact with others more than you used to?
18. (01) yes____ (02) no____ felt numb, like you do not have feelings anymore?
19. (01) yes____ (02) no____ been more forgetful than usual?
20. (01) yes____ (02) no____ misplaced things more often than usual?

In the past month have you....

21. (01) yes____ (02) no____ been unable to fall asleep at night?
22. (01) yes____ (02) no____ had your heart pound hard so you could feel it in your chest?
23. (01) yes____ (02) no____ felt like you were choking?
24. (01) yes____ (02) no____ not being able to complete simple or familiar tasks because you cannot pay attention?
25. (01) yes____ (02) no____ heard someone call your name, but when you looked, no one was there?

In the past month have you...

26. (01) yes____ (02) no____ lost weight, or noticed that your clothes are too loose and do not fit you anymore?
27. (01) yes____ (02) no____ gained weight beyond your usual weight, or noticed that your clothes are too tight?
28. (01) yes____ (02) no____ felt sad all of the time?
29. (01) yes____ (02) no____ feel hopeless or helpless, like nothing will ever improve?
30. (01) yes____ (02) no____ thought about ways to end your life?
31. (01) yes____ (02) no____ not gotten out of bed in the morning to do the things you need to do?
32. (01) yes____ (02) no____ not gotten dressed for the day?

33. (01) yes____ (02) no____ If you had a question, that was educational, financial, or health related, would you know who to contact?
34. (01) yes____ (02) no____ Are any of your immediate family members still in Bosnia or trying to relocate to Waterloo, Iowa?

Thank you for completing this questionnaire.